

**Funding and
Implementing
HIV/AIDS
Activities in the
Context of
Decentralization:
Ethiopia and
Senegal**

February 2001

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Partnerships
for Health
Reform



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Funded by:

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- > *enhanced organization and management of health care systems and institutions to support specific health sector reforms.*

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February 2001

Recommended Citation

Mbengue, Cheikh. February 2001. *Funding and Implementing HIV/AIDS Activities in the Context of Decentralization: Ethiopia and Senegal*. Special Initiates Report No. 34. Bethesda, MD: Partnerships for Health Reform Project, Abt Associates Inc.

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Contract No.: HRN-C-00-95-00024
Project No.: 936-5974.13
Submitted to: USAID/HIV/AIDS Division

and: Karen Cavanaugh, COTR
Policy and Sector Reform Division
Office of Health and Nutrition
Center for Population, Health and Nutrition
Bureau for Global Programs, Field Support and Research
United States Agency for International Development

The opinions stated in this document are solely those of the authors and do not necessarily reflect the views of USAID.

Abstract

Both Senegal and Ethiopia have recently undertaken changes in the political and financial administration of government services, decentralizing decisionmaking power to local levels. In Senegal, decentralization of health service planning and implementation to the district level poses both challenges and opportunities to the financing, treatment, and prevention of HIV. The positive consequences of decentralization are that local decision-making and implementation of HIV/AIDS activities are integrated into the health system, more resources can be made available for HIV/AIDS activities, and the public and private sectors plan jointly for HIV/AIDS services. However, some constraints posed by these reforms still need to be addressed. National coordinating bodies do not organize well with key health committees, and the roles of the various HIV/AIDS committees are not clearly understood. Non-governmental organizations (NGO) and community groups play a crucial role in the delivery of HIV/AIDS services, and in some cases are the exclusive service provider for the treatment of HIV/AIDS related illnesses. Decentralization in Ethiopia created a federal unit to coordinate health service provision and regional autonomous states in their planning and implementation services. In practice, however, these bodies do not function, and due to the lack of public service provision, treatment of HIV/AIDS is exclusively provided by NGOs. Prevention activities are not standardized, and there are imbalances between needs and resources at the regional level.

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Acronyms

ADB	African Development Bank
AIDS	Acquired Immunodeficiency Syndrome
ANCS	<i>Alliance Nationale Contre le SIDA</i> (National Alliance against AIDS)
ARV	Antiretroviral (anti-AIDS drugs)
CHU	<i>Centre Hospitalier Universitaire</i> (University Hospital Center)
CVM	<i>Centro Voluntary Marchigiani</i> (Nongovernmental Organization)
DAGE	<i>Direction de l'Administration Générale et de l'Équipement</i> (Directorate of General Administration and Infrastructure)
EU	European Union
FCFA	<i>Franc de la Communauté Francophone d'Afrique</i> (West African Currency)
GDAS	General Division of Administration and Supply
HIV	Human Immunodeficiency Virus
ICASO	International Council of AIDS Support Organizations
IDA	International Development Agency
IEC	Information, Education and Communication
IHDP	Integrated Health Development Program
NGO	Nongovernmental Organization
NACC	National AIDS Control Committee
NACP	National AIDS Control Program
OP	Operating Plans
PHR	Partnerships for Health Reform Project (USAID)
PLWHIV	Persons living with HIV
STI	Sexually Transmitted Infections
UNAIDS	United Nations Joint Program on HIV/AIDS
UNDP	United Nations Development Program
UNPF	United Nations Population Fund
UNICEF	United Nations Children Fund
USAID	United States Agency for International Development
WHO	World Health Organization

Conversion Rate

US\$1 = 729 FCFA

US\$1 = 8.26 ETB (Ethiopian Birr)

Acknowledgments

This work was made possible by the contributions of a number of professionals to whom I express my sincere gratitude. I would like to thank Dr. Gemechu Megersa, Anthropologist, and Girma Bekele, Economist, who conducted the study on Ethiopia, and Jan Valdelin, Abt Associates, who coordinated their activities; Papa Amadou Konte, Information Technologies (IT) Manager, who truly assisted in data input and manipulation for the study on Senegal; Charlotte Leighton, PHR, who offered constructive comments on the synthesis document, Whitney Schott, PHR, for her helpful assistance; and all the people in Ethiopia and Senegal who provided research teams and information for the studies.

Executive Summary

Objective

The objectives of these two studies were to determine how decentralization reforms have affected the funding and use of HIV/AIDS services in Ethiopia and Senegal. Insufficient quantitative data for the periods before and after reform prevented an in-depth evaluation of the impact of reform. However, the study did yield interesting findings on the funding and implementation of HIV/AIDS activities within the context of decentralization.

Methodology

In both countries, secondary data were obtained from planning documents, activity reports, and study reports. The Partnerships for Health Reform research teams investigated five regions in Senegal with two districts per region, and three regional states in Ethiopia with one zone in each state and one *wareda* (smaller administrative unit) per zone. The primary data were obtained in both countries through semi-structured interviews with government and non-government officials at the central and decentralized levels.

Institutional Framework

The Senegalese context is characterized by relative political stability that has made it possible to implement ongoing health reforms. In Ethiopia, however, there has been great political instability and the health system is being entirely rebuilt.

Senegal has undergone two decentralization reforms: the first was the adoption of the district system in the health sector in 1991, and the second was the transfer of new powers to local authorities in 1996 in multiple sectors, including health. Since 1986, HIV/AIDS activities have been coordinated by the National AIDS Control Committee (NACC) and implemented by the National AIDS Control Program (NACP). There are regional AIDS control committees and district anti-AIDS committees that are meant to work together for the NACC at the decentralized level.

Ethiopia underwent a major decentralization reform in 1985 in which nine regional states were created, each having considerable autonomy and responsibilities for managing different sectors, including health. Though the HIV/AIDS coordination unit was dissolved in 1985, in 1998 a federal coordination structure with regional committees was established in order to implement a 2000-2004 program funded by the World Bank.

Role of the Public Sector and Current Structure

In Senegal, the NACC does a relatively good job of coordinating activities, but some of its members are ill-informed about the HIV/AIDS activities planned at the decentralized level. This problem seems to stem from the fact that planning for HIV/AIDS activities is done more by the NACP than by the NACC, and communication between these entities is insufficient.

In principle, the district system provides an effective framework for the decentralization of HIV/AIDS activities, as it facilitates implementing interventions at the peripheral level, while including HIV/AIDS activities in the district's integrated activities package. However, most of the regional AIDS control committees are not operational, and some of the district anti-AIDS committees do not even exist. Furthermore, there is no legal framework mandating their existence.

In Ethiopia, neither the federal structure nor the regional committees envisioned in the 2000-2004 program is yet in existence.

Role of the Private Sector and Current Structure

In both countries, nongovernmental organizations (NGOs) play an extremely important role in the collective response to the epidemic. In Senegal, there is an umbrella organization of AIDS-control NGOs (International Council of AIDS Support Organizations) that is an active member of the NACC. However, it has very little institutional support and thus has difficulty properly coordinating NGO activities at the decentralized level. As a result of the lack of public intervention in the health sector in Ethiopia, all HIV/AIDS activities are carried out by NGOs, which are hence the only important providers of HIV/AIDS services and support.

Funding of HIV/AIDS Activities

In Senegal, the distribution of resources budgeted for 2000 shows that the amount of resources budgeted for the peripheral level is nearly triple the amount for the regional level, demonstrating a genuine decentralization of resources for HIV/AIDS services. However, "zoning," a decentralized funding strategy for donor resources, has created major imbalances between regions and districts in Senegal. HIV/AIDS activities are determined by the resources and funding mechanisms of each donor rather than on relative need.

In Ethiopia, most resources for HIV/AIDS services are concentrated in Addis-Abeba, which exacerbates the difficult funding situation in other areas. Furthermore, the federal government of Ethiopia makes it difficult for NGOs to access donor funding. In Senegal, on the other hand, the NACP directly funds NGO activities using both government and donors resources.

Local authorities at decentralized levels in Senegal do not yet prioritize the funding of programs, which is particularly acute in the case of the AIDS program. Most of the responsibility transferred to local authorities is related to the management of the health facilities themselves, not the activities taking place within them.

In Ethiopia, regional states are unable to fund priority programs such as HIV/AIDS activities because tax reform has pushed most of the resources up to the federal level.

Assessment of the Implementation of HIV/AIDS Activities

Prevention activities are relatively well carried out in Senegal through the district system, which offers a good framework for implementation. There are some deficiencies in the district system, however, that have made it difficult to implement certain programs. In Ethiopia, despite a paucity of HIV/AIDS programs, the study shows that they seem to be achieving some behavior change in the areas in which sensitization activities take place.

In both countries, support for persons living with HIV (PLWHIV) is primarily provided by NGOs, with minor assistance from the NACP in Senegal supporting associations of PLWHIV.

In Senegal, inadequate re-training and supervision of providers at the decentralized level seriously handicaps the proper implementation of counseling activities. Little attention has been paid to this area by the NACP for several years. One would expect clinical management of HIV/AIDS cases to work well in Senegal through the referral system. However, in most clinical areas there are no formal contracts between regional hospital employees and the national referral services. This gap in the referral system generates a lack of technical cooperation for the management of AIDS cases between levels (national and regional).

In Ethiopia, the deficiencies of the hospital system, both in terms of human and physical resources, does not permit satisfactory clinical management of HIV/AIDS cases. Senegal, however, has had a management program using anti-retroviral drugs since 1988. This program has not yet been decentralized, but preparations are underway to undertake similar reforms.

1. Introduction

In Africa, over the past few decades, decentralization reforms have been implemented in the health sector to close the gap between beneficiaries and decision and management centers. Such reforms not only directly affect the health system, but there may also be more general political reforms significantly affecting health system performance. Responsibilities, financial resources and powers at the local or peripheral level have increased, making it possible for the system to effectively carry out the new role with which it has been entrusted.

In the health sector, the decentralization reforms have been studied and presented on numerous occasions, yet no specific emphasis has been placed on the impact they may have on priority programs. In order to address this issue, Partnerships for Health Reform set out to perform two studies (Senegal and Ethiopia) on the impact that decentralization reforms have had on the financing and service utilization of priority programs. HIV/AIDS was selected as an important priority service program in which decentralization reforms may have serious affects.

Unfortunately, the lack of sufficient, relevant data for the periods before and after the reforms has made it difficult to comprehensively evaluate the impact of reforms. Hence, this study has focused on the funding and implementation of HIV/AIDS activities within the context of decentralization. Senegal and Ethiopia have had different reform experiences within contexts having considerably different characteristics.

Whereas the AIDS control program in Senegal is generally considered exemplary in Africa, the Ethiopian AIDS control coordination unit has simply been dissolved. Senegal has been implementing its health reforms for several decades within a context of relative political stability and massive support from donors, while Ethiopia has been troubled by a cycle of political instability that has had a negative impact on its health system.

In addition, Senegal is a Francophone country, in which the French administrative tradition has left its mark, in contrast to Ethiopia, an Anglophone country. Some clarifications on the meaning of decentralization concepts to the French and Anglo-Saxon traditions may be necessary. Most often, decentralization reforms result in two main structures: decentralization-deconcentration or decentralization-devolution.

In the decentralization-deconcentration, the central administrative authority transfers a number of responsibilities to peripheral administrative units that have relative autonomy for management and decision-making, yet still depend on the central government where the hierarchical authority is housed. In contrast, decentralization-devolution implies that powers are transferred to a local authority that is a legal entity with considerable independence vis-à-vis the central political authority, and whose legitimacy generally has its roots in universal suffrage.

Whereas in the Anglo-Saxon tradition decentralization implies both types, the French tradition holds that decentralization only refers to decentralization-devolution, when the entity to which the powers and responsibilities are transferred is a legal and financially autonomous entity. Thus, the strengthening of peripheral administrative units throughout the health district system is called “health services decentralization” under the Anglo-Saxon concept, whereas it is simply called “deconcentration” in the French tradition.

For the sake of conceptual conformity, this study will use the Anglo-Saxon concept, since the World Health Organization (WHO) has adopted it in its different publications on decentralization reforms. Both types of decentralization are of interest to us, because the first exists in the Senegalese example, and the second pertains to the experience of both countries, albeit in different forms.

In 1991, Senegal's health system changed with the adoption of the district system where there was a transfer of management powers from the central level to the peripheral level (the health district), which is the operational framework for providing primary health care. Therefore, this reform is decentralization-deconcentration. Later, in 1996, Senegal adopted a decentralization-devolution reform in which the state transferred powers to local authorities (regions, communes and rural communities) in multiple sectors, including health.

In 1995, Ethiopia adopted a constitution that created regional states with significant autonomy in several sectors, including health. This kind of reform is decentralization-devolution.

This report hopes to draw lessons that may help to improve the implementation of decentralized activities in countries undertaking such reforms, with particular focus on HIV/AIDS services, and where possible, compares the health sector situation with the education sector. Recommendations suggest ways to protect priority programs within the context of decentralization, while at the same time optimizing opportunities within this context.

First, the institutional framework of the reforms, funding and the implementation of activities in the context of decentralization, will be addressed. The study of the institutional framework will be used to identify the mechanisms for coordinating and decentralizing HIV/AIDS activities, with special emphasis on the role of governmental structures vis-à-vis non-governmental structures. Next the relationship between funding for HIV/AIDS activities and the institutional framework will be addressed, with a focus on source and distribution of resource flows. The study follows with an analysis of the implementation of HIV/AIDS services within this new context. Lastly, recommendations suggest ways in which countries can incorporate protection mechanisms to permit greater mobilization and more efficient distribution of resources, as well as a more rational implementation of activities. The situation of the education sector will be addressed for purposes of comparison.

Due to its exploratory nature, this study in no way claims to be exhaustive. Instead, it is a first attempt to understand the connection between decentralization reforms and priority health programs. As such, the study proposes to pave the way to broader and more detailed studies that will devise programs to help health systems operate more effectively and to make people healthier.

2. Methodology

The case studies of Senegal and Ethiopia synthesized in this report looked at the funding and implementation of HIV/AIDS services within the context of decentralization. This is an exploratory study that aims to provide the instruments for analysis that can be extended to other countries and other priority health programs.

2.1 Sampling

The Senegal study was performed in the medical regions of Dakar, Diourbel, Kaolack, Louga and Saint-Louis. In addition to the Dakar region, where the national capital is located, two USAID intervention regions (Kaolack and Louga) were selected in addition to one United Nations Development Program intervention region (Diourbel) and one European Union intervention region (Saint-Louis).

In each region, two districts were selected:

- > Dakar Nord and Dakar Sud for the Dakar region.
- > Diourbel and Mbacké for the Diourbel region.
- > Kaolack and Kaffrine for the Kaolack region.
- > Saint-Louis and Matam for the Saint-Louis region.

Health facilities and organizations were also visited at the regional level.

The Ethiopian study concerned the administrative region of Addis Abeba and the regional states of Amhara and Oromia. The Addis Abeba region was chosen because it is where the capital is located, whereas Amhara and Oromia were selected as contrasting examples; HIV/AIDS activities are widespread in Amhara but practically nonexistent in Oromia.

The *warda* (administrative unit) of Finnote-Selam, in the zone of West Gojam, was chosen for the regional state of Amhara and the *warda* of Sayyo, in the zone of Western wallega, was selected for the state of Oromia.

2.2 Data Collection

The study is based on secondary data obtained using planning documents, evaluation reports, survey reports, activity reports and policy papers. These documents pertain not only to the AIDS control program, but to nongovernmental organization (NGO)s, donors and other parties as well. Primary data were obtained from individual semi-structured interviews with:

- > Public sector officials at the central and decentralized levels;

- > NGO officials and officials of AIDS control associations, both at the national and decentralized levels;
- > Health professionals responsible for the case management of people who are HIV positive;
- > Officials of decentralized political entities;
- > Officials of development partner institutions.

In addition to the qualitative data obtained from interviews, it was possible to collect quantitative data in Senegal on the volume of funding and other topics. These data were taken from year 2000 operating plans approved by the Health Ministry. The data on the resources to be used for HIV/AIDS activities were extracted from plans outlining the commitments of different partners to fund health services at the central and decentralized levels. Therefore, the data is not actual financing sources since the NACP system is unable to quantify in real terms the resources used in HIV/AIDS control.

Data on the resources used in health structures in Senegal could not be obtained since in regional referral hospital units, the state's contribution is essentially intended to provide care for all patients. Thus, it is not possible to differentiate between resources used to care for patients with HIV/AIDS from resources used for other patients. Nevertheless, a study with a broader scope could spend more time using detailed data from these units to disaggregate HIV/AIDS information. This exercise would make it possible to assess the contribution of patients with HIV/AIDS at the hospital structure level. This information would be useful to policymakers and donors, even though in a context with low prevalence, the percentage of the contribution from patients to the national funding of HIV/AIDS activities may be negligible.

The individual experiences of each country resulted in some adjustments to methodology. Thus, in the study of Ethiopia, additional quantitative data on knowledge, attitudes and practices of the people in the two selected zones were analyzed.

3. Institutional Framework

3.1 Background

Senegal is located at the western tip of Africa and covers an area of nearly 200 thousand square kilometers, with a population of about 9 million inhabitants. The country is divided into 10 regional administrative units, each with three department administrative districts, which are in turn divided into *arrondissements*. Senegal has three types of local authorities with elected councils: the region, commune and rural community. The ten regions cover the territory of the administrative regions, while the 48 communes and 320 rural communities were determined using geographic, demographic and economic criteria.

Ethiopia is located in the western part of the African continent and is five times larger than Senegal, with an area of over 1 million kilometers squared, and with a population six times larger, of around 60 million people. The country is divided into regional states with an elected executive. The states are divided into zones that include basic administrative units called *wardas*.

Senegal's health system is organized as a pyramid, comprised of:

- > at the top, a policy level comprised of structures at the central level (Office of the Minister, divisions and national departments);
- > at the middle, a strategic level comprised of ten medical regions, which cover the ten regional administrative units; and
- > at the peripheral level, an operational level comprised of 52 health districts.

The Ethiopian health system is comprised of:

- > at the federal level, a federal minister;
- > at the regional level, a regional health bureau which is the highest executive level in the health system;
- > at the zone level, a zonal health department; and
- > at the basic level, a *warda* health office.

3.2 Framework for Implementing HIV/AIDS Activities

With the emergence of the first AIDS cases in 1985, Senegal's Health Ministry initiated an approach which, in 1987, culminated in the establishment of a National AIDS Control Committee (NACC), in charge of designing a national HIV/AIDS prevention strategy and coordinating all actions for managing the epidemic. The NACC includes representatives from a dozen ministerial departments involved in controlling the epidemic, as well as representative of the Council of AIDS

Control, nongovernmental organization (NGO)s, the presidents and vice presidents of specialized working groups, and representatives of other institutions. It has an ethics, legal and research advisory group, a clinic-counseling group, an epidemiological group, an information, education, and communication (IEC) group and a “blood bank” group.

The National AIDS Control Program (NACP) is the framework for the coordinated implementation of HIV/AIDS activities and for the management of state resources, to which partners and donors allocate resources. The Chairman of the NACC, the Coordinator of the NACP, the presidents of the working groups, representatives of AIDS control, NGOs, and one representative of the Ministry of Planning comprise the small committee, which meets monthly.

In Ethiopia, in 1985 the Health Ministry, under the military government, established a unit tasked with performing studies to identify a strategy and provide an appropriate response to the epidemic using regional committees. Resources of the military government were bolstered by contributions from local and foreign sources. However, in the early 1990s, this unit was dissolved. As a result, Ethiopia currently has no coordinated system for providing HIV/AIDS services. At the same time, a national HIV/AIDS policy was adopted in August 1998, aiming to strengthen the regional committees and eventually, to create a national committee.

3.3 Overview of Decentralization Reforms

3.3.1 Senegal, Decentralization-deconcentration Reform

In the spirit of World Health Organization (WHO) recommendations, Senegal chose to decentralize its health services by adopting the district health system in 1991. The district is an integrated, implementing, operational unit for primary care. The district is relatively autonomous in planning and implementing activities, as well as managing resources.

The NACP has adjusted to this new political context by decentralizing its activities through regional IEC programs and by incorporating HIV prevention programs into the package of the district activities. The NACP’s new organizational chart takes into consideration the idea of setting up regional AIDS control committees and district AIDS control committees.

The integration of the NGO Board and AIDS associations inside the NACC and the small committee can be seen as an acknowledgment that civil society plays an important role in mobilization against the epidemic. Development partners and donors that have supported the NACP since its inception have joined forces under the decentralization framework by directly providing their support to the medical regions and districts for implementing activities. They also fund central level activities.

Donor intervention has been decentralized using “zoning” principles, where the country is divided into donor-specific intervention zones. Each donor chooses to work in one or more zones for the purpose of being more efficient and consistent and in order that its programs have greater impact.

The health activities planning process starts from the bottom and moves up, with district plans, regional plans and a national health and social development plan (1998-2007). The first phase is comprised of the Integrated Health Development Program (IHDP). It covers the period from 1998 to 2002. The annual operating plans (OP) are carried out under the control of the IHDP’s Support and Monitoring Unit. In conjunction with the employees of the General Division of Administration and

Supply (GDAS) under the Health Ministry, they provide the resources required for carrying out the OPs, unless the donor in question chooses to use its own procedures.

3.3.2 Senegal and Ethiopia, Decentralization-devolution Reforms

The Senegalese constitution stipulates that local authorities will help implement health activities and requires them, in conjunction with the state, to provide for the health of the people. The concept of autonomous local governments with elected councils and their involvement in organizing the authorities and freedoms is also affirmed in the constitution.

In 1996, the creation of the region as a local authority, in addition to the commune and rural community, included a major transfer of responsibilities to local authorities in nine development sectors, including health. The region, commune and rural community received powers mainly for the management and maintenance of health infrastructure. However, the region was given the additional responsibility of developing and carrying out action plans for controlling major epidemics, vaccinating against communicable diseases and ensuring hygiene measures.

The communes manage operating funds for health districts, meaning that mayors have an important role in carrying out health activities. Moreover, local authorities are mandated to do integrated planning; regional development plans, commune investment plans and local development plans must all include health development plans from the different levels.

The Ethiopian reform was motivated by the necessity for the central government to safeguard national unity after the secession of Eritrea. Thus, nine new regional states were created based on national and ethnic identities. These states are highly autonomous. The regional states run their own affairs in every sector of activity. These broad powers are justified in that, according to the constitution, “Every nation, nationality, and people in Ethiopia has the right to self-determination, including the right of secession.” It is understandable that in exchange for the right of secession, the states will be given equally broad responsibilities. Thus, each region makes sovereign decisions about its budget and freely identifies its activities without being required to have federal government approval. Health activities are part of this decentralized system. Regional health bureaus are at the top of the hierarchy, followed by zonal health departments that in turn supervise the *wareda* health offices.

In both countries, decentralization reforms place local authorities (in Senegal) and regional states (in Ethiopia) at the center of the health sector. These decentralized levels of the health system therefore have a considerable impact on implementing health activities, including HIV/AIDS activities.

3.3.3 Institutional Framework and the Role of Public and Private Actors

3.3.3.1 Public Sector Actors

In Senegal, public sector actors include the agencies in the Health Ministry, from the central level to the peripheral level, and local authorities, which are legally considered divisions of the state. In Ethiopia, they include the federal Ministry, the regional health bureaus and their divisions. An important difference between the two is that Senegal has active public agencies, while in Ethiopia the public services are virtually defunct at all levels and have not implemented any activities.

The NACC in Senegal functions relatively well and does a good job of coordinating HIV/AIDS activities. The NACP, which implements those activities, is also considered by the United Nations Joint Program on HIV/AIDS as one of the best programs in Africa (along with Uganda's program). The medical regions and health districts implement the HIV/AIDS activities they are in charge of, which are detailed in their operating plans.

AIDS control is not considered to be as much a public health priority in Ethiopia as it is in Senegal. In Ethiopia, the new national committee and the regional committees are not yet operational, though they were supposed to take over the 2000-2004 program funded by the state with a loan from the World Bank. It is remarkable that in such a large country that has not been spared by HIV/AIDS, there has been no public agency to control the epidemic for several years now. Unfortunately, it is impossible to accurately determine whether the dissolution of the national AIDS control unit is the consequence of decentralization. However, dissolution was brought about by political reforms along with a change in the political regime, and may be interpreted as the ministry's desire to pass on responsibility for AIDS control to the regional states. Even if we accept this assumption, the relay is clearly not working at the decentralized level. However, the need to transfer powers to the regional states does not justify dissolving the central unit.

The active role played by public agencies in Senegal does not cover, however, certain weaknesses in AIDS control in the country. The NACC is not fully carrying out its task of coordinating AIDS control programs, since some major decisions are made unbeknownst to its members. For example, some members of this body are not informed of the content of OP for HIV/AIDS activities, as if the role the NACC were supposed to play in planning were instead played by the NACP's technical team under the Health Division's authority. One might wonder how NACC members, and even members of the small committee, can play their role if they have no information about the content of the operating plans of the central, regional and peripheral levels. Similarly, the regional AIDS control committees chaired by regional governors are not functional, as they meet only when an NACC delegation happens to be in the area, or when there are high-profile HIV prevention campaigns.

Though the district AIDS control committees exist on paper, they do not exist in practice. In fact, there is still no law entitling them to officially exist. The failure of the regional committees to operate, combined with the non-existence of the district committees, has a negative impact on the coordination of peripheral level programs. Medical regions and health districts also have no existing framework for coordination with NGOs and other private players.

Local authorities participate little in base-level health planning, partly because there is a shortage of information about health issues. In addition, the vast majority of local health committees are not operational. Management committees, which were meant to be bodies for discussion and district administration, have been installed in only a very few cases. Therefore, it is understandable how local authorities may be relatively uninterested in managing health programs, leading them to look at health issues narrowly, from the standpoint of managing funds transferred by the state for the operation of health facilities.

3.3.3.2 Private Sector Actors

NGOs and community associations play a crucial role in HIV/AIDS service provision in both countries. In Senegal, the earliest education campaigns on HIV/AIDS were conducted by NGOs. Civil society has clearly led the way, followed by public agencies. The important role played by NGOs and associations in Senegal can explain their representation in the NACC and even in the small

committee through their International Council of AIDS Support Organizations (ICASO) coordination structure, present throughout the country with more than 200 member associations. However, with the exception of international NGOs, only three out of four AIDS control NGOs and associations are involved in more than two regions of Senegal.

The lack of widespread coverage is exacerbated by the fact that ICASO's regional units are not currently in operation. As a result, major potential for strengthening the role of NGOs in the decentralization process is lost. Given the lack of institutional support from the NACP, ICASO presence is very weak and suffers from more serious institutional weaknesses than other member associations.

In Ethiopia, NGOs are critical because they work almost exclusively to control HIV/AIDS. However, in the epidemic's early years, the government excluded NGOs from government-run programs in certain urban areas. As in Senegal, NGOs contributed to breaking the silence surrounding the epidemic in Ethiopia. Unfortunately, the scarce financial resources available did not cover certain regional states, such as Oromia. The concentration of NGOs and religious support organizations in Addis-Abeba highlights the shortcomings of decentralization and signals a worrisome imbalance between central and regional levels.

However, in the State of West Gojam, an NGO has implemented an effective AIDS control program that promotes synergies among all the local players. The NGO CVM has a project that has led to intersectoral cooperation, including the zonal health department, the education department, the Ethiopian Orthodox Church Diocesan Office, the Islamic Council, and others. This NGO program has also helped create several AIDS control clubs and associations. The program is an example of how NGOs are taking the lead on HIV/AIDS, surrounded by governmental structures which then follow.

4. Funding of HIV/AIDS Activities within the Context of Decentralization

Due to donor confidence in Senegal's HIV/AIDS program, there is major support to the national program, while in Ethiopia, political instability and the federal government's lack of interest in HIV/AIDS activities has resulted in donors bypassing a national program.

4.1 Data Availability

The lack of an AIDS control program in Ethiopia causes funding data to be highly unbalanced compared to data on the funding of activities in Senegal (despite the fact that the NACP in Senegal has no reliable data on funding trends—neither national nor local).

As indicated in the methodology section, the year 2000 OP were used to analyze the funding of HIV/AIDS activities in Senegal.

The areas of funding were broken down as follows:

- > IEC includes funding for all AIDS sensitization activities, not including activities carried out during specific mobilization days and weeks
- > Where funding is generally intended for IEC, it is not possible to discern how much is going to any given program. Based on estimates made by officials of health regions and districts, a distribution key was used. It is based on the assumption that one-fifth of IEC activities pertain to sexual transmitted infections (STI) and AIDS.
- > DAYS includes funding activities during mobilization days and weeks, which are basically sensitization activities
- > TRAINING includes funding for AIDS or STI/AIDS training activities
- > TRAINING/STI includes funding for training activities limited to STI
- > SURV/SAF includes funding for epidemiological surveillance activities and transfusion safety activities.
- > CONDOMS includes funding for condoms. The distribution key used assumes that two-thirds of condoms are used to prevent STI/AIDS and the other third are for family planning.
- > OPS/EQUIP includes funding for operations and equipment.
- > RESEARCH includes funding for research.
- > SUPPORT includes funding used to support people living with HIV.

- > COUNSELING includes funding for counseling, including training in counseling for persons living with HIV and their families.
- > COORDINATION includes funding for coordinating activities or funds that are so general that they cannot be allocated to any specific purpose.
- > NGOs includes funding for NGOs. Funding for NGOs is used to pay for several programs. Again, the distribution key is based on the assumption that NGOs spend one-fifth of these funds on STI/AIDS activities.
- > Resources for supplying drugs and providing treatment are not explicitly listed in the OPs. However, it should be noted that funding to support people living with HIV is mainly used to supply drugs for opportunistic diseases to which carriers of HIV are exposed.

Funding sources have been given the same names as those in the OP. The clarifications are justified for the AUTHORITIES column, which references funding by local authorities, the COMMITTEES column, on funding for health committees, and IDA, for funds from the World Bank. The contributions of the government of Senegal are not explicitly listed in the OP, though contributions do exist since funds provided by development banks [World Bank–International Development Agency (IDA) and African Development Bank (ADB)] are loans as opposed to donations. Therefore, the funds that are provided by the World Bank and the ADB are in fact a contribution by the government. The government of Senegal also contributes to funding the program to provide anti-retroviral drugs to HIV positive people, but the corresponding resources are not in the OP.

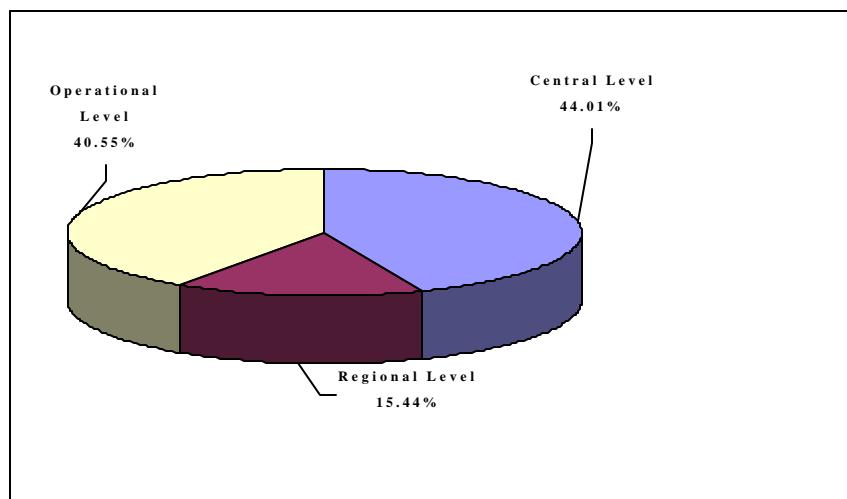
It should be noted that the data used here are actually funding obligations, as there is little reason to expect large differences between commitments made and actual spending. The lack of accurate and reliable information on the volume of actual spending is obviously a major limiting factor to assessing the impact of decentralization on HIV/AIDS funding.

4.2 Overall Funding of HIV/AIDS Activities at the Central and Decentralized Levels

The review of the funding distribution in Senegal among the central, regional and operational levels, shows that 44 percent of funds go to the central level, 15 percent to the regional level and 41 percent to the district level. Clearly, priority is given to decentralized activities since the operational level receives roughly three times as many resources as the regional level.

Table 1. Funding Distribution among the Central, Regional and Operational Levels, Year 2000, Senegal

Central Level	Regional Level	Operational Level
570,353,000 F	200,167,000 F	525,496,000 F
\$815,604	\$286,239	\$751,459



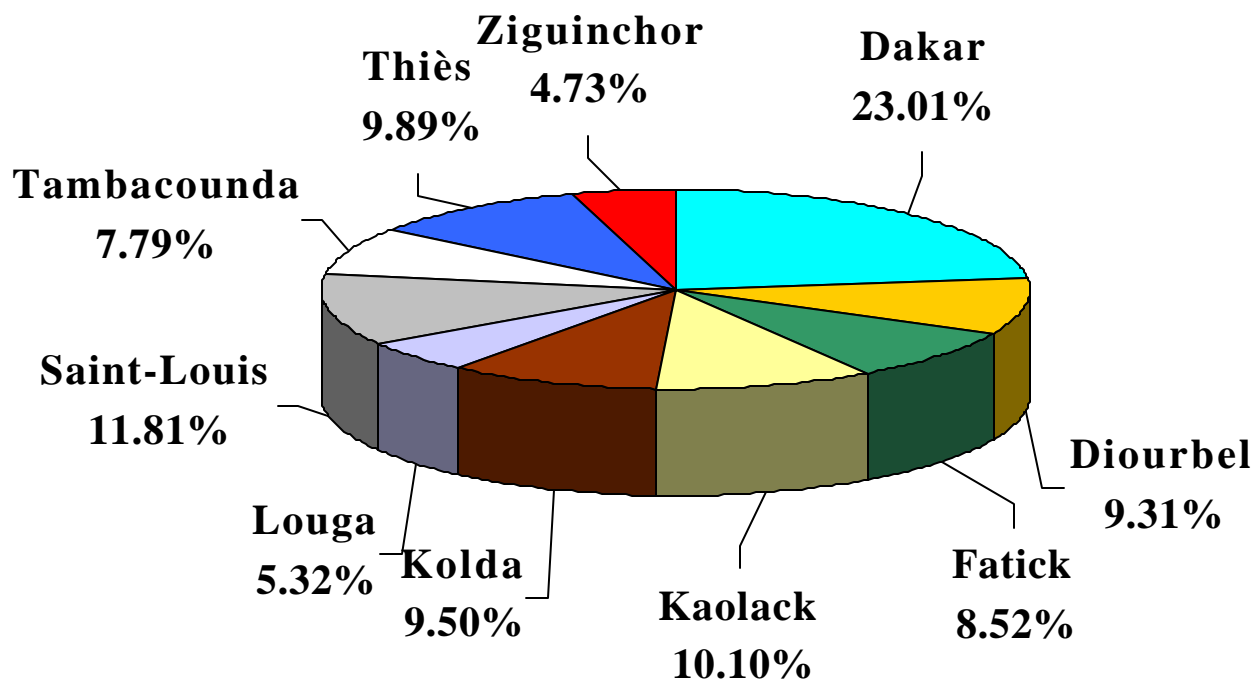
Though a large percentage of funding goes to the national level, more than half of the funds go toward operations and equipment, epidemiological surveillance and transfusion safety. All of these require a central level with substantial resources. In Ethiopia, such a comparison is not possible because there is currently no unit at the central level.

4.3 Funding HIV/AIDS Activities in the Decentralized Structures

In Senegal, the review of funds distribution among the ten regions of the country show that nearly a quarter of the funds (23 percent) go to the Dakar region alone, followed by Saint-Louis (12 percent), Kaolack (10 percent), Thiès (10 percent), Kolda (10 percent), Diourbel (9 percent), Fatick (9 percent) and Tambacounda (8 percent). Louga (5 percent) and Ziguinchor (5 percent) receive very little if any funding.

Table 2. Funding Distribution by Region, Senegal

Dakar	Diourbel	Fatick	Kaolack	Kolda	Louga	St-Louis	Tamba	Thiès	Ziguinchor
167,008,000 F	67,580,000 F	61,836,000 F	73,284,000 F	68,970,000 F	38,609,000 F	85,707,000 F	56,517,000 F	71,794,000 F	34,358,000 F
\$238,821	\$96,639	\$88,425	\$104,796	\$98,627	\$55,198	\$122,551	\$80,809	\$102,660	\$49,120



According to the officials interviewed, including members of the NACC and NACP, funds are not distributed using clear, rational or need-based criteria, but rather according to the volume of commitments made by each donor. The "zoning" strategy for decentralized funding is problematic as it creates a situation in which the implementation of HIV/AIDS activities within regions and districts is heavily dependent on the individual requirements of the donor in question. Thus, some regions have practically no HIV/AIDS activities, as donor procedures are cumbersome or ill-adopted, whereas in neighboring zones, funds may expeditiously and activities may be effectively carried out. Finally, when the region or district is not fortunate enough to be chosen by a "wealthy" donor, HIV/AIDS control activities may be considerably limited.

Distribution, therefore, is not the expression of a reasoned choice or based on need as one might hope. Instead, it is somewhat similar to demographic distribution, with the following percentages:

- > Dakar: 23 percent of funding for 24 percent of the population
- > Diourbel: 9 percent of funding for 9 percent of the population
- > Kaolack: 10 percent of funding for 11 percent of the population
- > Louga: 5 percent of funding for 5 percent of the population

- > Saint-Louis: 12 percent of funding for 8 percent of the population

The skew between central and decentralized funding is much greater in Ethiopia. During the past four years, financing for Addis-Abeba has been 49 times greater than funding for the state of Amhara, and 38 times higher than for the state of Oromiya. In this case, it is not the zoning strategy that is a problem, but the lack of a coherent and consistent strategy for funding HIV/AIDS activities in the context of decentralization.

In Senegal, the percentage of funding used for purchasing condoms (between 39 percent in Dakar and 63 percent in Kaolack) shows the emphasis placed on prevention in a country where the prevalence rate is reported to be 1.5 percent.

Table 3. Dakar Region Funding, by Source

USAID	IDA	WHO	SANFAM	COMMs	Germany	UNICEF	UNDP	AUTH-ORITIES	UNPF
74,316,000 F	19,032,000 F	180,000 F	210,000 F	970,000 F	13,200,000 F	10,000,000 F	21,050,000 F	2,850,000 F	25,200,000 F
\$106,272	\$27,215	\$257	\$300	\$1,386	\$18,876	\$14,300	\$30,101	\$4,075	\$36,036

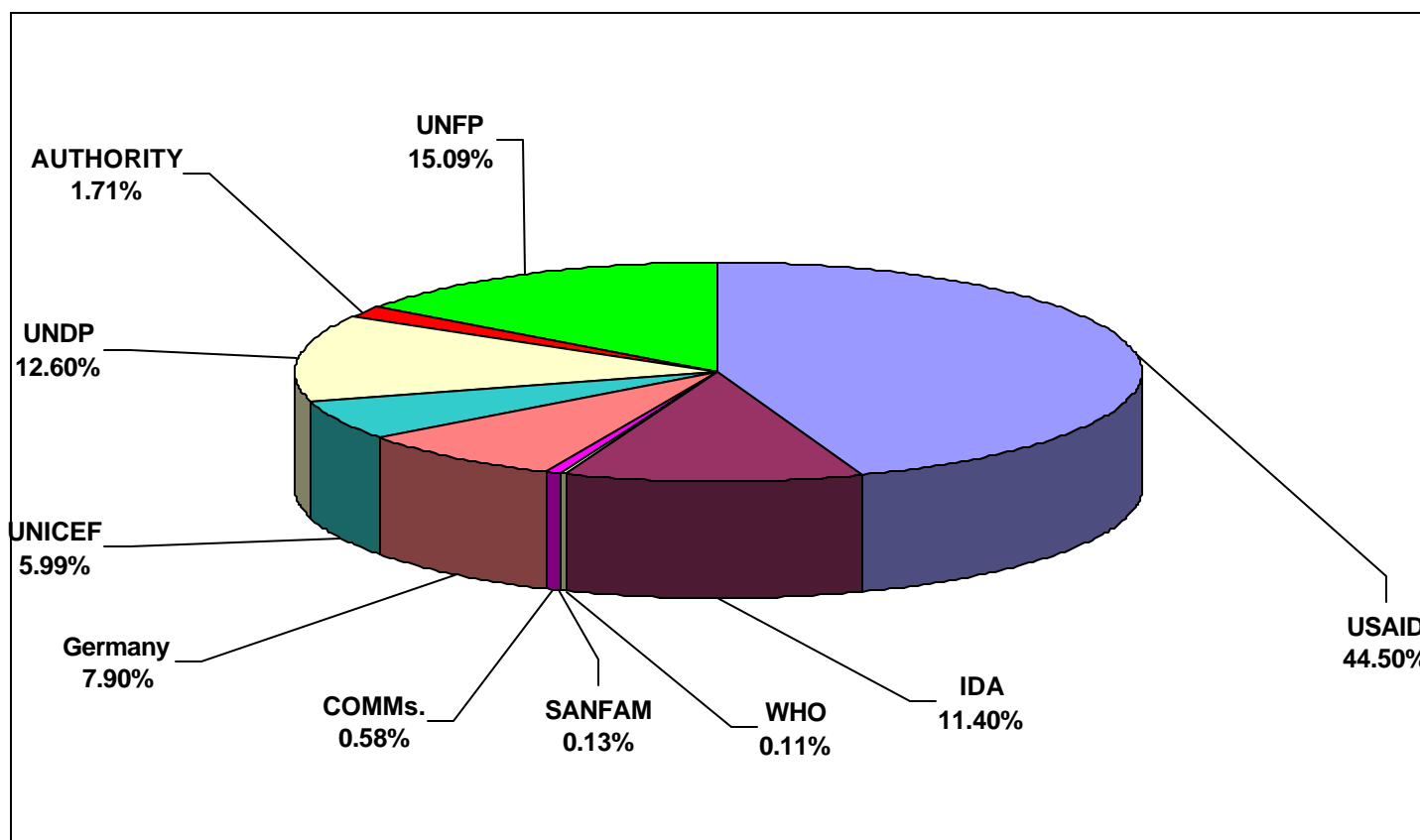


Table 4. Diourbel Region Funding, by Source

USAID	IDA	COMMS	UNDP	WHO
37,700,000 F	13,300,000 F	100,000 F	14,500,000 F	1,980,000 F
\$53,911	\$19,019	\$143	\$20,735	\$2,831

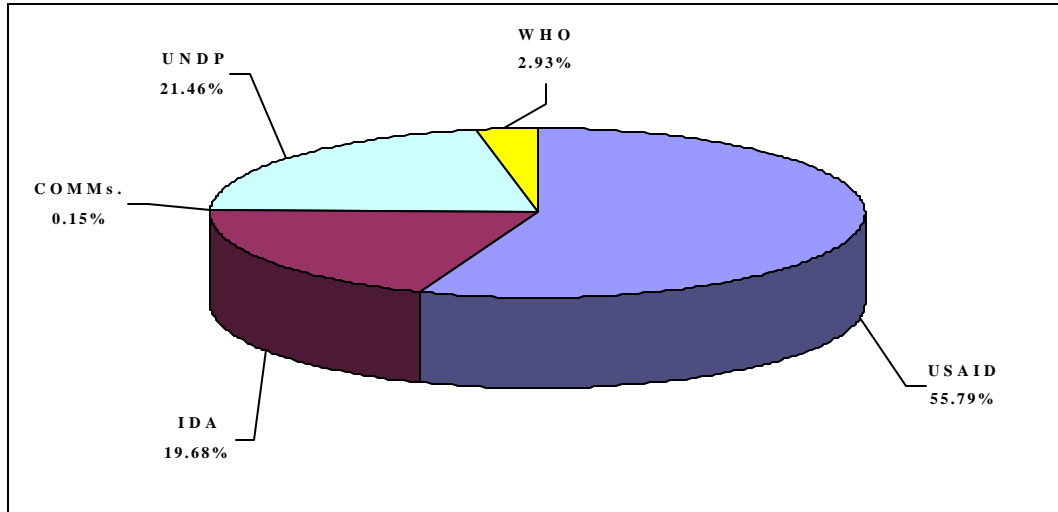


Table 5. Kaolack Region Funding, by Source

USAID	IDA	COMMS	UNDP	WHO
52,264,000 F	370,000 F	5,800,000 F	13,900,000 F	950,000 F
\$74,737	\$529	\$8,294	\$19,877	\$1,358

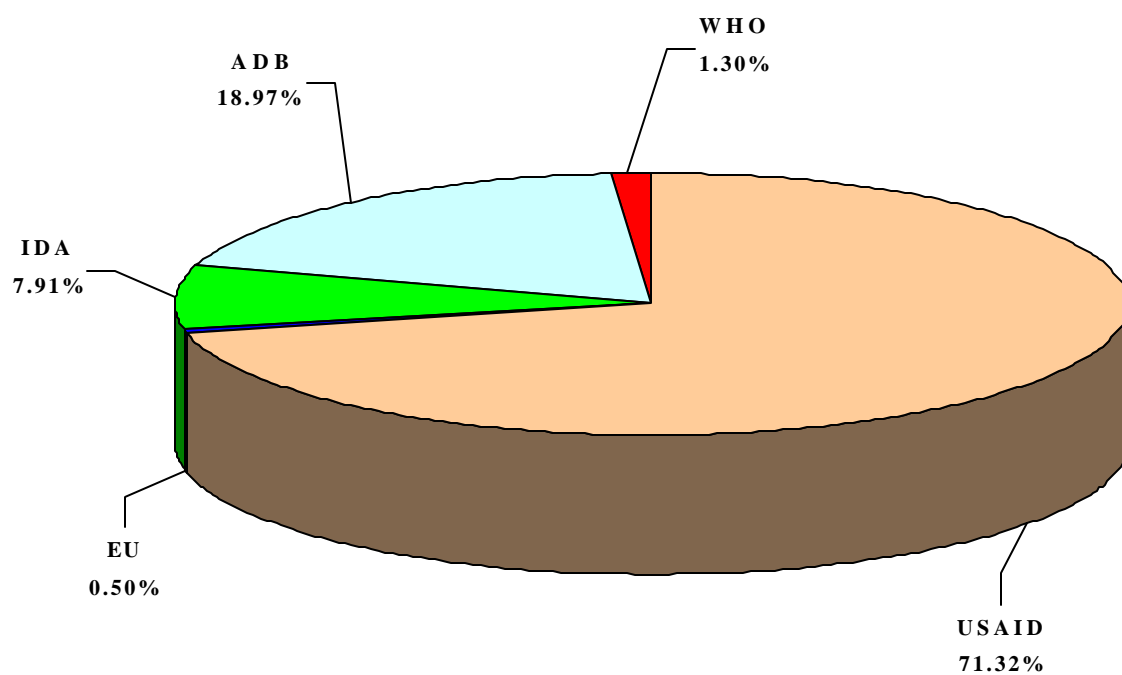


Table 6. Louga Region Funding, by Source (in millions of FCFA)

USAID	IDA	PLAN International
28,854,000F	7,742,000F	2,013,000F
\$41,261	\$11,071	\$2,878

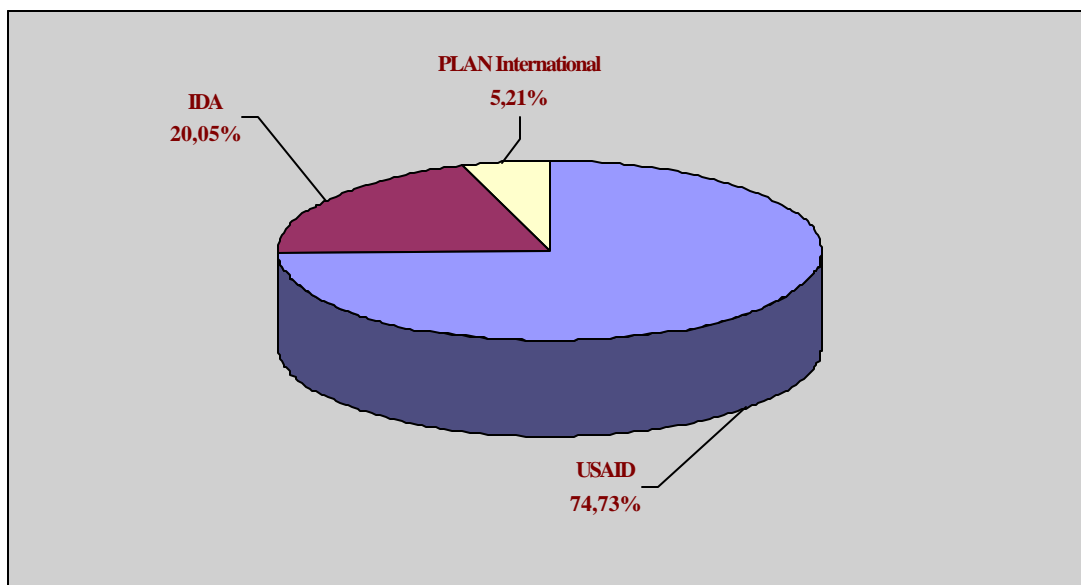
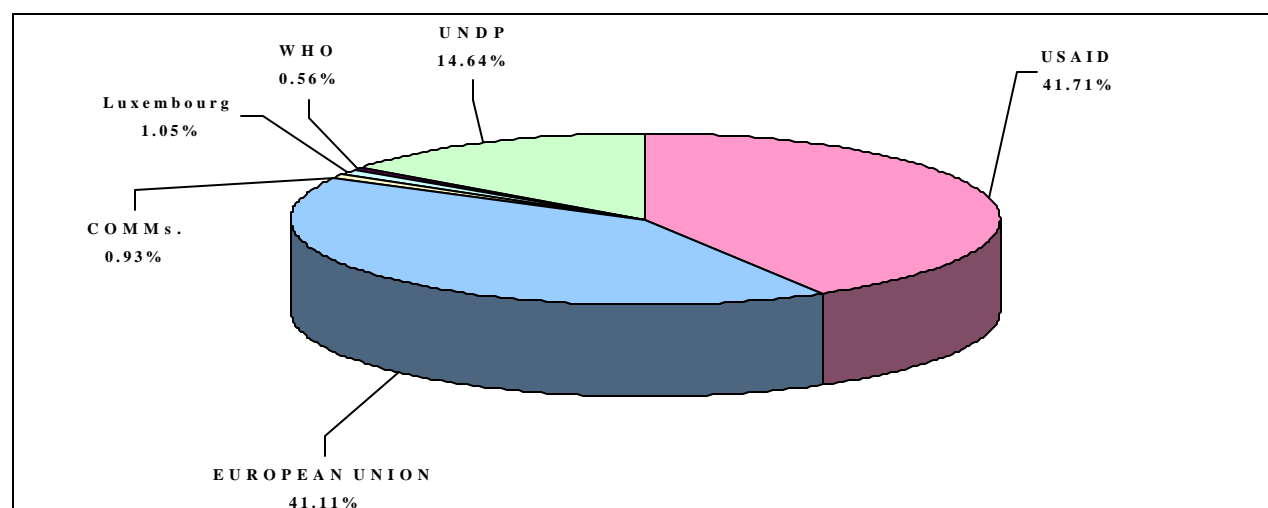


Table 7. Saint-Louis Region Funding, by Source

USAID	EU	Comms.	Luxembourg	WHO	UNDP
35,747,000F	35,230,000F	800,000F	900,000F	480,000F	12,550,000F
\$51,118	\$50,378	\$1,144	\$1,287	\$686	\$17,946



Since USAID provides almost all the condoms, it is understandable that this donor's share of total funding ranges from 45 percent in Dakar to 75 percent in Louga. Even in regions such as Diourbel and Saint-Louis where other donors intervene, USAID still ranks first in funding.

Other than Dakar, no region receives funding for HIV/AIDS from the local authorities. Moreover, even in Dakar, funding is not earmarked for HIV/AIDS, but rather distributed as a contribution to IEC, a portion of which is supposed to be used for AIDS prevention. This issue is further addressed in a later section.

Many regions receive funding for only certain activities related to HIV/AIDS. For example, Diourbel does not receive funding for epidemiological surveillance/transfusion safety; Kaolack does not receive funds for counseling, coordination, research or support for PLWHIV; Louga does not receive funds for counseling, research or coordination; and Saint-Louis does not receive funds for epidemiological surveillance/transfusion safety. Only half of the regions have a sentinel surveillance site; those without such sites receive no funds for surveillance.

Table 8. Dakar Region Funding, by Activity

Training	IEC	Condom	Other	Days	Equipment	Research	Support	SURV/ SAF	Counseling	NGO	Coordination
7,100,000F	35,000,000 F	64,467,000 F	180,000F	15,320,000 F	700,000F	5,000,000F	1,850,000F	720,000F	3,250,000F	32,250,000F	1,100,000F
\$10,153	\$50,050	\$92,187	\$257	\$21,907	\$1,000	\$7,150	\$2,645	\$1,029	\$4,647	\$46,117	\$1,573

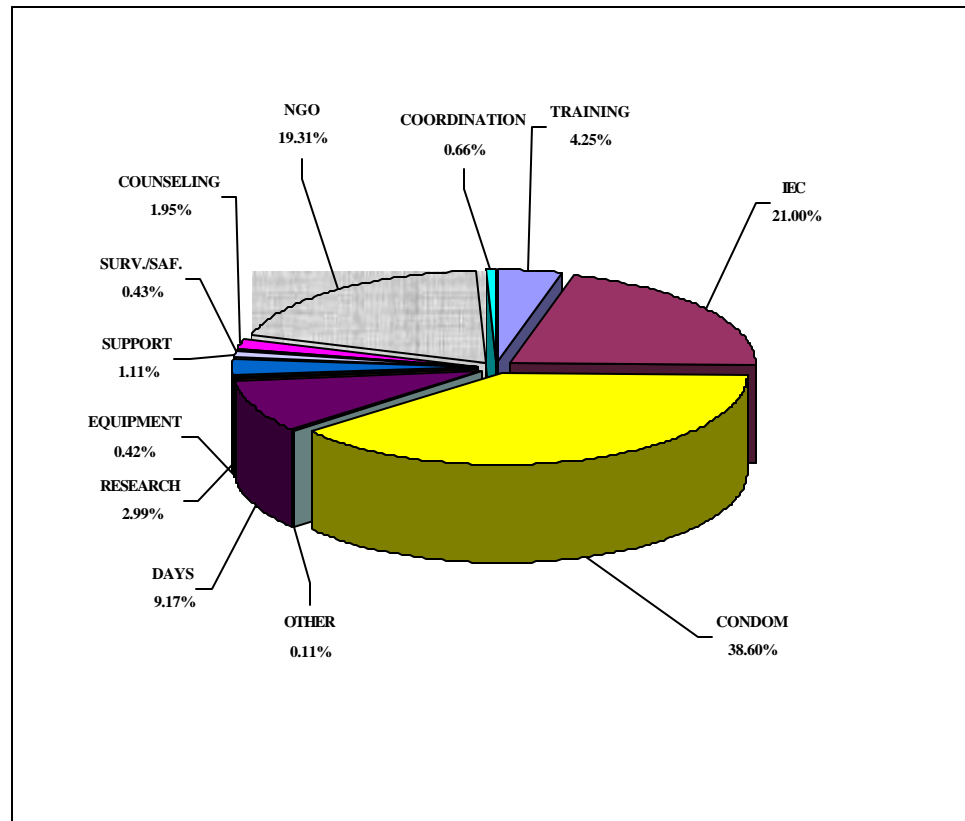


Table 9. Diourbel Region Funding, by Activity

Training	IEC	Condom	Other	Days	Research	Support	Coordination	Counseling	NGO
5,600,000F	6,100,000F	37,700,000 F	180,000F	6,200,000 F	900,000F	1,000,000F	500,000F	1,000,000F	8,500,000F
\$10,153	\$8,723	\$53,911	\$257	\$8,866	\$1,287	\$1,430	\$715	\$1,430	\$12,155

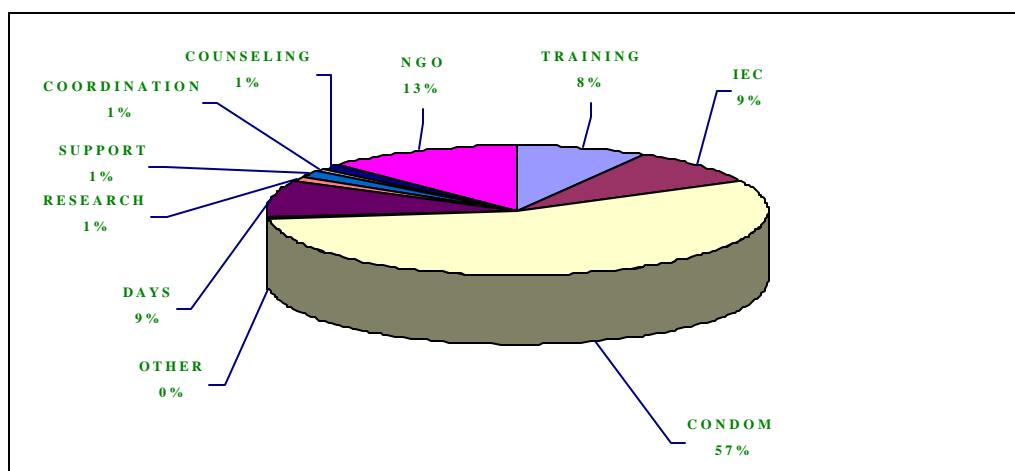


Table 10. Kaolack Region Funding, by Activity

Training	IEC	Condom	Other	Days	Training / M	SURV./SAF.	NGO
370,000F	233,400F	46,280,000F	300,000F	1,100,000F	1,980,000F	520,000F	19,300,000F
\$529	\$3,337	\$66,180	\$429	\$1,573	\$2,831	\$743	\$27,600

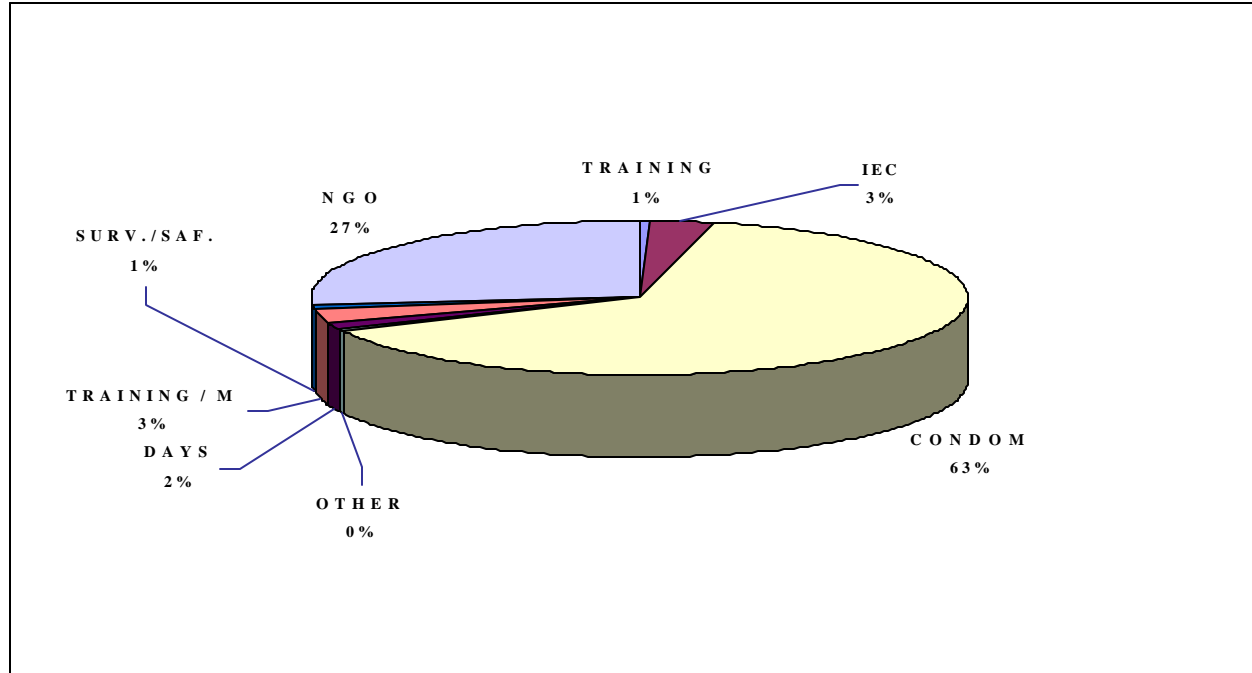


Table 11. Louga Region Funding, by Activity

Training	IEC	Condom	SURV./SAF.	Days	Training/M	NGO
2,383,000F	2,634,000F	23,710,000F	520,000F	2,250,000F	2,612,000F	4,500,000F
\$3,407	\$3,766	\$33,905	\$743	\$3,217	\$3,735	\$6,435

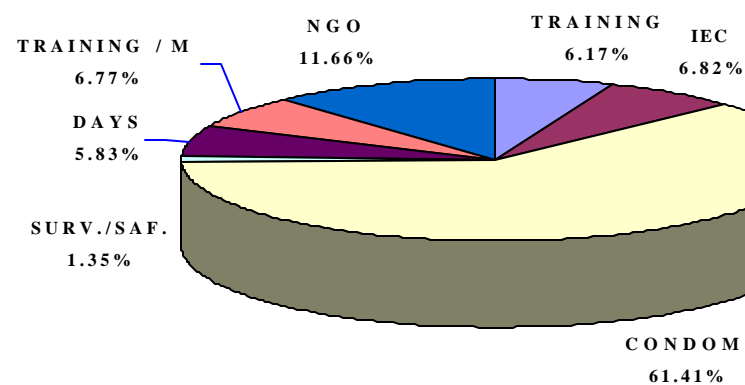
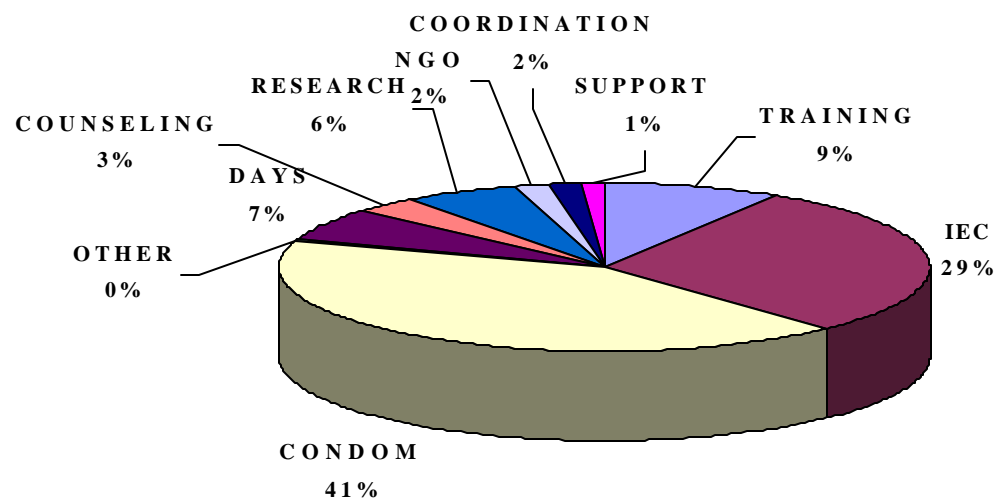


Table 12. Saint-Louis Region Funding, by Activity

Training	IEC	Condom	Other	Days	Counseling	Research	NGO	Coordination	Support
7,600,000 F	24,820,000 F	35,747,000 F	300,000 F	5,550,000 F	2,500,000 F	5,000,000 F	1,500,000 F	1,330,000 F	1,000,000 F
\$10,868	\$35,492	\$51,118	\$429	\$7,936	\$3,575	\$7,150	\$2,145	\$1,902	\$1,430

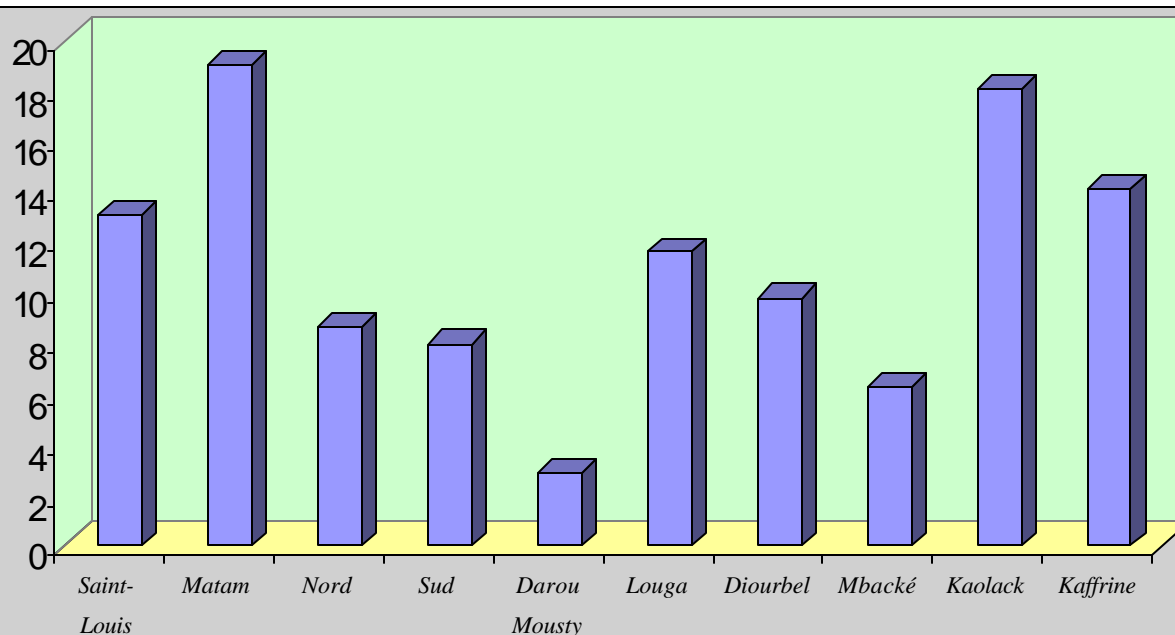


In all five regions, counseling, epidemiological surveillance/transfusion safety and research receive funding that averages about 2 percent, while funds for operations/equipment are provided only for Dakar, which receives only 700 thousand FCFA (approximately US\$1,000).

The review of funding in the ten districts studied reveals significant funding imbalances: funds for HIV/AIDS activities are six times higher in Matam than in Darou Mousty. It should be noted that, funds for condoms excluded, six districts (Dakar Nord, Darou Mousty, Diourbel, Mbacké, Kaolack and Kaffrine) receive less than 1 million FCFA (US\$1,500) for their activities. The district of Diourbel, though home to the regional capital, has no funding at all for its HIV/AIDS activities when condoms are not included. Under such conditions, there is reason to wonder one can really speak of a decentralized AIDS control policy. The situation in Diourbel is similar to that of the state of Oromia in Ethiopia.

Table 13. Funding Levels for the 10 Districts Studied in Senegal

Saint-Louis		Dakar		Louga		Diourbel		Kaolack	
Saint-Louis	Matam	Nord	Sud	Darou Mousty	Louga	Diourbel	Mbacké	Kaolack	Kaffrine
13,053,00 0F	19,040,00 0F	8,653,000 F	7,965,000 F	2,942,000 F	11,568,00 0F	9,800,000 F	6,280,000 F	18,048,00 0F	14,128,00 0F
\$18,665	\$27,227	\$12,373	\$11,390	\$4,207	\$16,542	\$14,014	\$8,980	\$25,808	\$20,203



IEC activities, which account for most HIV/AIDS activities at the operational level, do not receive more than 500 thousand FCFA (US\$700) in eight of the 10 districts. The two districts in the region of Diourbel (Mbacké and Diourbel) receive no funding at all for IEC. However, Mbacké is highly exposed to HIV as it is a major destination for immigrants and is one city away from a large religious complex. Mbacké is a place where people go when they want to shed the strict morals of the religious complex.

Strikingly, counseling and support for PLWHIV receive no funding at all in the 10 districts, not even in Matam, which seems to be the district most affected by the epidemic. Similarly, research is not funded in any of the districts except Matam, where a study is scheduled worth 2.5 million FCFA (about US\$3,000). Training is funded in six of the 10 districts. In the districts of Darou Mousty, Kaolack and Kaffrine, which receive no resources for HIV/AIDS training, there are funds for STI training.

Table 14. Funding for the 10 Districts Studied in Senegal, by Activity

	St-Louis		Dakar		Louga		Diourbel		Kaolack	
	St-Louis	Matam	Dkr Nord	Dkr Sud	Darou Mousty	Louga	Diourbel	Mbacké	Kaolack	Kaffrine
Training	1,600,00 0F \$2,288	2,490,00 0F \$3,560	370,000 F \$529	370,000 F \$529	0	2,013,00 0F \$2,878	0	100,000 F \$143	0	0
IEC	1,520,00 0F \$2,173	500,000 F \$715	345,000 F \$493	1,595,00 0F \$2,280	345,000 F \$493	345,000 F \$493	0	0	345,000 F \$493	345,000 F \$493
Condom	9,133,00 0F \$13,060	12,047,0 00F \$17,227	7,738,00 0F \$11,065	5,800,00 0F \$8,294	2,347,00 0F \$3,356	9,210,00 0F \$13,17	9,800,00 0F \$14,014	5,480,00 0F \$7,836	17,333,0 00F \$24,786	13,413,0 00F \$19,180
Other	0	0	0	0	0	0	0	0	0	0
Days	0	1,500,00 0F \$2,145	200,000 F \$286	200,000 F \$286	0	0	0	700,000 F \$1,000	0	0
Op/Equip	0	0	0	0	0	0	0	0	0	0
Research	0	2, 500,000 F \$3,575	0	0	0	0	0	0	0	0
Counseling	0	0	0	0	0	0	0	0	0	0
Support	0	0	0	0	0	0	0	0	0	0
Reagents	0	0	0	0	0	0	0	0	0	0
NGO	800,000 F \$1,144	0	0	0	0	0	0	0	0	0
Surv.Saf	0	0	0	0	0	0	0	0	0	0
Training/ STIs	0	0	0	0	250,000 F \$357	0	0	0	0.37 \$529	0.37 \$529
Coordination	0	0	0	0	0	0	0	0	0	0
Totals	13,053,0 00F \$18,665	19,037,0 00F \$27,223	8,653,00 0F \$12,373	7,965 \$11,390	2,942,00 0F \$4,207	11,568,0 00F \$16,542	9,800,00 0F \$14,014	6,280,00 0F \$8,980	18,048,0 00F \$25,808	14,128,0 00F \$20,203

4.4 NGOs and Funding for HIV/AIDS Activities

Senegal's Health Ministry has institutionalized funding for NGO activities as they are considered important partners of the government. In addition to funds for sensitization activities, which often include an HIV/AIDS component, NGOs receive funds from the NACP budget. Some NGOs, through their international contacts, raise funds directly from abroad, though these resource flows cannot be quantified as they are outside the scope of the NACP budget. Moreover, some larger NGOs, particularly international NGOs, fund other NGOs and associations. This is the case of the Alliance Nationale Contre le SIDA (ANCS), which provides financial and technical support to local NGOs. ANCS also sometimes supports HIV/AIDS activities in zones where NACP involvement is weak, such as the Kolda region in 1999. NGO activities are occasionally funded by the NACP without the awareness of officials of the medical region or district. This central level interference in the activities at the peripheral levels makes it difficult to carry out a coherent, decentralized HIV/AIDS program.

In Ethiopia, the two states of Amhara and Oromiya, except for the contributions from Christian Relief Development Association members and other NGOs, receive no funding for HIV/AIDS activities—neither from bilateral donors, multilateral donors, nor the government. The situation in Ethiopia is particularly difficult because the few efforts to provide HIV/AIDS services come from NGOs, yet the federal government insists that outside financing be set aside exclusively for government agencies and not NGOs. These government agencies have only a weak ability to absorb funds and are not in the business of HIV/AIDS service provision. The fact that NGOs are not eligible for these funds is a tremendous waste and may explain the why United Nations Population Fund (UNPF), United Nations Development Program (UNDP) and other multilateral organizations have no HIV/AIDS component in their programs in Ethiopia, since they receive no requests from the government for such a component.

Moreover, the regional states and NGOs in Ethiopia are in a situation of potential conflict as they are in direct competition for resources: when an NGO receives a contribution from the federal government, the corresponding amount is reduced from the total quota the government has to give to the state in question.

4.5 Senegal's Local Authorities, Ethiopia's Regional States and Funding for HIV/AIDS Activities

In Senegal, the State annually allocates resources called endowment funds to local authorities. These funds are meant to enable them to assume the new responsibilities that have been devolved to them. Since the powers transferred to the regions, communes and rural communities are essentially management responsibilities, it is not surprising that local authorities do not have special resources to contribute to funding programs and activities.

Also, the management of endowment funds creates a conflict between local authorities and officials of the health structures. Health structures find that since local governments manage the operating funds of health facilities, when services are not operating correctly, it is due to elected officials depleting health funds for other purposes.

Another reason local authorities do not contribute to HIV/AIDS programs, is that they have relatively few resources at their disposal. They often have difficulty paying for certain basic operating expenses, such as their employee's salaries and their electricity bills. Under these circumstances, they cannot be expected to financially support health programs. Even in Matam, where HIV/AIDS has

become a visible priority problem, local governments have not raised resources to control the epidemic. It is also widely perceived in Senegal that health programs, particularly the HIV/AIDS program, have substantial resources. Therefore, local government officials, instead of thinking about funding HIV/AIDS activities, express the desire to obtain NACP grants to carry out activities.

The contribution of local authorities to education is also insignificant in most cases. They are often accused of not using the endowment funds for their intended purposes. These funds invariably arrive from the local authorities several months late, which seriously jeopardizes efficiency. In addition, local governments tend to use endowment funds, health funds and education funds in particular, to cover operating expenses because they have such limited resources.

The case of the Commune of Dakar is somewhat different in that it sets aside almost 13 percent of its budget for health. If we know that the budget is over 12 billion FCFA, we can expect that the commune of Dakar would allocate significant resources to funding HIV/AIDS activities. Unfortunately, this is not the case, as nearly the entire health budget of the commune of Dakar covers investment and operating costs. The commune finances the construction, maintenance and operation of all the health centers and units located in its jurisdiction, and pays the wages of their employees.

In Ethiopia, the contribution to the HIV/AIDS program made by regional states is almost nil. Above and beyond the lack of political commitment to the AIDS issue, the states do not have sufficient resources to assume the tremendous expenses brought on by decentralization. Political reforms went hand in hand with tax reform giving tax revenues to the central government. In the education sector, the lack of resources is painfully obvious, though still not as desperate as the situation of HIV/AIDS activities.

5. Implementation of HIV/AIDS Activities within the Context of Decentralization

5.1 Prevention

Prevention is one of the most important tools for controlling AIDS, especially in the context of underdeveloped countries where it is difficult to bear the huge cost of paying for treatment services for HIV positive people. Senegal's prevention efforts, which began in 1987, have contributed to the low prevalence rate. The availability of condoms at every level of the health pyramid has also helped tremendously in combating the spread of HIV/AIDS.

AIDS sensitization has been incorporated into IEC activities at the level of all health districts in Senegal, offering several benefits. First, it opens up the opportunity to use funds and logistical resources for HIV/AIDS messages that are allocated to general district IEC activities. In addition, it means that every point in the country could be reached in the context of a standardized and consistent approach. However, when the district system fails, the shortcomings spread into HIV/AIDS activities, and IEC in particular.

For example, in the district of Matam, the district team had not conducted a supervision visit of health units for five months because of logistical and resource constraints. Supervision visits are the only opportunity for contact between the district supervisor in charge of sensitization and the localities. With no supervision, district supervisors can not be certain that sensitization activities for HIV/AIDS are being carried out. In addition, seven of the 48 district health units are closed since they have no nurse. Clearly, a lack of trained, designated staff at the peripheral level makes sensitization even more difficult. In a district so heavily affected by HIV/AIDS, sensitization should be carried out routinely, or the consequences of a decentralized system can be tragic.

In Ethiopia, sensitization activities make up most of the NGO work. For example, in the regional state of Amhara, CVM has invested heavily in producing IEC materials and has trained more than 600 counselors. A survey on knowledge, attitudes and practices showed that people in the area where CVM works had significantly better information than those of Dembi Dolo in the state of Oromio where HIV/AIDS activities are nonexistent.

At the same time, some actors have limited their prevention and control support for HIV/AIDS to the national level contributions, leaving a dearth of support in some regional states.

5.2 Psychosocial Management

In the Senegal study, the findings on the psychosocial management of patients with HIV/AIDS were the most disconcerting, particularly in terms of communicating HIV positive status to patients and providing support to PLWHIV. Some health professionals give their patients an HIV test without their consent and with no pre-test counseling. In addition, they are often untrained and uncomfortable talking with patients about being HIV positive. The lack of consent and pre-test counseling are

serious issues. Moreover, in some of the units visited, the principle of confidentiality was violated by the disclosure of HIV status to the family without the patient's consent.

Findings also demonstrated an inadequate retraining and supervision policy for providers at the regional and district levels. Not surprisingly, the NACP has had no significant counseling activity for two years. That this situation persists and that providers are left to their own devices seems to confirm the viewpoint of one health professional, who holds that for HIV/AIDS care, "what is happening is not decentralization, but abandonment."¹

Support for PLWHIV is one of the weakest points of Senegal's decentralized health system. In fact, other than in Dakar, only the cities of Saint-Louis, Louga and Tambacounda have any structure to support PLWHIV. Such support associations suffer from a lack of resources as well as a lack of clear NACP policy for psychosocial management of PLWHIV.

The National Network of Persons Living with HIV, which includes associations of people affected by and infected with HIV, receives no real support from the NACP to help PLWHIV in the different regions. Other than limited support from some NGOs, PLWHIV and their associations receive no significant assistance.

This situation is most problematic in the district of Matam, where HIV/AIDS is devastating the population, yet very little is being done to help PLWHIV. The hospital that serves Matam does not even have a social worker who could provide minimum psychological support to PLWHIV.

In Ethiopia, counseling programs are run by NGOs but their efforts are weak. Activities to support PLWHIV are also limited, though in the Addis Ababa administrative region some funding is given to income-generating activities for PLWHIV and their families.

5.3 Clinical Management

In Senegal, clinic management of HIV/AIDS cases essentially takes place at the level of the departmental, regional and national hospitals. In Kaolack, the regional hospital's infectious disease unit is the referral structure, while in Louga, Saint-Louis and Diourbel, the internal medicine unit in the regional hospital plays this role. The departmental hospital in Ourossogui, located in the jurisdiction of the district of Matam, sees AIDS cases from this zone in its medical unit.

Regional hospitals refer patients to the infectious diseases unit of the national referral structure, the University Hospital Center (CHU). Unfortunately, however, there is no historical information provided about the cases they refer. Therefore, technical cooperation is not possible, nor is information shared between the national structure for referrals and the decentralized clinical management structures. This deficiency is not specific to the treatment of HIV/AIDS, but applies to other specialties as well. There are no real contacts between the CHU and employees of the regional hospitals.

For example, the CHU and the NACP have not visited the infectious diseases unit at the hospital in Kaolack for six years, and the head of Diourbel hospital's internal medicine unit has never met with any delegations from the CHU or NACP for the four years he has been in that position. The polio control program, on the other hand, has excellent relations with his unit.

¹ Interviews with health professionals, 2000.

Such lack of contact between the central and decentralized levels may explain the shortcomings of certain peripheral services, such as providing pre-test counseling and violation of patient confidentiality regarding HIV status.

In Diourbel, the internal medicine unit in the hospital does not have any specific statistics on the number of AIDS patients, though periodic supervision from the central level could have correctly provided this information. This type of problem, fortunately, does not exist at the hospital in Saint-Louis, where the professionals in charge of HIV/AIDS cases are developing interesting programs with the NACP.

In Ethiopia, clinic management is seriously handicapped because of deficiencies in the hospital system. The situation is alarming in hospitals such as Dembi-Dollo where, instead of the six physicians required, there are only two interns on staff. This lack of sufficient resources results in deplorable consequences for patient management in every area, including AIDS. What is worse, in any given year, drugs are only available for a period of two months.

The situation is so dire that NGOs are forced to provide support to government agencies for them to obtain minimal equipment. In this way, CVM provided a blood bank to the Felege Hiwot Hospital in Finnote Selam in the regional state of Amhara.

In Senegal, the NACP has had a program to manage HIV positive people using anti-retroviral (ARV) drugs since 1988. This project is funded by the state in the amount of 250 million FCFA for the first year, with an increase of 50 million FCFA per year after that. This aspect of the program is not decentralized, despite the fact that some physicians outside of Dakar have already been trained to manage ARVs. The NACP has stated that it is willing to extend this program to other regions, provided that its financial resources are increased and that the regions have a technical requirement for monitoring HIV positive people who are taking ARVs.

There is no program to provide ARV drugs in Ethiopia.

6. Conclusions

Decentralization reforms in Senegal and Ethiopia have had various impacts on HIV/AIDS activities due to significant differences in the political and health contexts, and also the specific features of the reforms in question.

6.1 Positive Potential of Decentralization

The internal reforms required for a decentralized district system appear to have the potential to positively impact the health system and priority service programs, making health activities more efficient. First, the decentralization of health services in Senegal has created a framework conducive to the implementation of NACP activities, particularly with the inclusion of HIV/AIDS activities in the district's integrated activities package. Second, IEC for HIV/AIDS, which plays a pivotal role in the AIDS control program, has benefited from the considerable resources allocated to general IEC activities in the district. In addition, district planning procedures encourage cooperation between the public sector and NGOs. In fact, HIV/AIDS activities have demonstrated a model of collaboration that deserves to be expanded to other health activities. Finally, decentralization has allowed the HIV/AIDS program to be applied to every level of the health pyramid and reach even the most peripheral levels of the health system.

6.2 Challenges of Decentralization

At the same time, the decentralization reforms of creating local authorities in Senegal or regional states in Ethiopia appear to have more debatable consequences, as they are designed to resolve problems that are more general in nature and not specific to health. The challenges posed by decentralization affect HIV/AIDS activities, often with severe consequences. The lack of routine supervision and control of the decentralized level by the central level, and the relative lack of interest in health activities such as HIV/AIDS demonstrated by some local decision makers, are both issues that need to be addressed. Similarly, the lack of real accountability for the NACC and its members in the planning and monitoring of activities generates a problem that could be corrected by improved information sharing between the NACP and the NACC.

The fact that regional and district AIDS control committees are currently not functional is also a major constraint, as these committees could help the teams in the medical regions and health districts coordinate more effectively and bolster the actions of HIV/AIDS service providers. Also, the new responsibilities assigned to Senegal's local authorities were mainly for managing health structures. Since these responsibilities do not include support for health programs, and since higher level managing committees are not functional, the regions, communes and rural communities are not at all involved in health program design or implementation. Thus, local authorities do not recognize the HIV/AIDS program as their area of responsibility, and they therefore do not allocate funds for the program. This has resulted in under-funding of health structures, indirectly penalizing HIV/AIDS activities.

6.3 Mixed Results

In Ethiopia, the creation of autonomous regional states unfortunately coincided with the elimination of the central HIV/AIDS activities coordination unit. Thus, both from the standpoint of funding and activity implementation, decentralization has made no contribution to AIDS control. However, this regrettable situation should not be considered the fault of reform, but instead is due to the lack of a political resolve to effectively rise to the challenge of the epidemic.

In both Senegal and Ethiopia, NGOs play a major role in HIV/AIDS service provision. The example of Ethiopia shows the important contribution that NGOs can make when the public structures are failing. In assisting the non-governmental sector to coordinate its activities down to the peripheral level, decentralization in the health sector is enhanced considerably.

It is evident from the this study that the donor strategy for funding decentralized activities known as “zoning” creates severe imbalances among regions and districts, particularly for HIV/AIDS activities. Zoning has its advantages, such as the visibility and cohesion of each donor’s activities. However, it is important that the NACP strive to correct funding disparities, taking into account the specific needs of each zone to prevent the situation of some districts not receiving any funds for counseling or support for PLWHIV, as is currently the case in Matam.

6.4 Remarks

In Africa, the decentralization process has become so widespread that it is clear it is at the core of most development issues. This study paves the way for more research on the impact of decentralization on priority services. Future studies must be structured to take into account the extreme diversity of contexts and the specific features of each decentralization experience.

In Senegal, the transfer of powers came with a transfer of resources through the endowment fund, but Ethiopian regional states are unable to be effective because the funding system has not been decentralized and they remain without resources.

7. Recommendations

Based on the experiences of Senegal and Ethiopia, a number of recommendations regarding the implementation of decentralization reforms may be made. Specific recommendations regarding overall reform implementation, organizational structure, resource allocation, monitoring and evaluation systems, follow.

7.1 Overall Implementation

Though the background and context within which decentralization reforms have been implemented varies significantly by country, it is important to seize the potential positive aspects of these contexts so that the health sector can optimize its chances to achieve the goals set for its different priority programs.

When new decentralization reforms are designed, analyses of the potential impacts these reforms may have on HIV/AIDS and other health activities should be undertaken. Strategies to advocate the health sector needs and interests should also be developed before reforms are implemented to ensure that needs are met.

7.2 Organizational Structure

The institutional framework for the management of AIDS control should be adjusted to the decentralization context so that at each level of intervention, a coordination structure is able to organize and coordinate public and private actions and serve as an advocate for the HIV/AIDS program. For Senegal, this means that the NACC at the central level must fully exercise its powers. The regional and district anti-AIDS committees must either be formally established or given incentives to function. Opening up these structures to representatives of local authorities, regional states and other actors would help not only to involve them in planning and implementing the AIDS program, but it would also encourage them to help fund the activities.

Since considerable powers are given to the local authorities in the health sector in Senegal, the local elected officials could be represented on the NACC through the Senegal Association of Mayors and the Senegal Association of Chairpersons of the Rural Council. The regional councils would be represented on the regional AIDS control committees, while the municipal and rural councils would be represented on the district anti-AIDS committees.

District committees that include all key actors could more correctly support the work of health professionals by bolstering community management of the epidemic. In addition, they would fulfill the important role of a framework for cooperation and coordination, which the peripheral level needs in order to implement all actors' activities in a coordinated way, informing local health authorities and other partners. Moreover, resources and interventions would be more streamlined, and duplication avoided. Consequently, it would be possible to more accurately evaluate the volume of resources invested in each zone.

The decentralized committees should also be made accountable through mandatory approval at the local level. As NGOs and associations often receive funds based on strong support at the central level (rather than effectiveness in the field or coordination with other activities), such an approval system would ensure better coordination at the peripheral level.

The new regional committees set up in Ethiopia and the new federal coordination structure must obtain strong institutional support from donors if they are to effectively catch up with this country's major delays in controlling AIDS. It is important to put in place a system whereby NGOs are not marginalized under decentralization, both because they have experience that should guide the work of the new structures, but also because, as in Senegal, the flexibility of their organization allows them to work more efficiently than any other player in certain key areas such as psychosocial management.

Also, institutional support should be provided to NGOs' coordination structures so that they can set up units at the periphery which in turn can strengthen the actions of the various levels of anti-AIDS committees established by the government at the central level. NGOs are in a good position to help strengthen these decentralized committees and to enhance the work of civil society.

Special emphasis should be placed on bringing together health professionals and officials of political decentralization structures to maximize understanding of health sector issues. In addition to involvement in AIDS control committees, local elected officials should be encouraged to be members of larger health management committees. In Senegal's case, the failure of health center management committees (which are chaired by the mayors) to function is a major handicap.

7.3 Resource Allocation

Several issues regarding the financing of HIV/AIDS activities can be suggested:

1. The imbalances in the funding of decentralized levels should be corrected. One possibility is to provide resources from the central level to zones that have received inadequate funding through zoning. Transfers may be made from funds of the state, equity or loans made by development banks.
2. The activities of each decentralized level should be based on need, especially in the most affected zones, so that HIV/AIDS activities solve existing problems, as opposed to simply applying one standard developed at the central level.
3. The direct funding by donors of decentralized programs, controlled at the central level, should be encouraged, in order to enhance coordination of HIV/AIDS activities at the periphery.
4. Local resource mobilization should be made part of decentralized cooperative agreements with donors to provide incentives to the decentralized political bodies to find resources for HIV/AIDS activities.
5. Local authorities, especially in heavily affected areas, could be offered partnership contracts based on "matching." This strategy involves providing substantial support to authorities that agree to use their funds to help finance planned health activities. In the zones in which HIV/AIDS is a major problem, such as in Matam, matching activities could naturally

include a strengthened commitment from all the players, and from the local authorities in particular, to help control the epidemic.

6. Special emphasis should be placed on allocating resources according to the newly transferred responsibilities.

7.4 Monitoring and Evaluation

A senior level focal point in charge of routine monitoring of the connection between the decentralization reforms and health activities should be established at the Health Ministry. This activity could take place through annual or semi-annual meetings. Within the context of decentralization, such a mechanism would strongly support health activities in general, and HIV/AIDS activities in particular.

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